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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA

IN RE: DIGITEK®
PRODUCT LIABILITY LITIGATION

Master Docket No.

MDL No. 1968

PLAINTIFF: [redacted]
(name)

DIGITEK® PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Fed. R. Civ. P. 33 and as responses to requests for production pursuant to Fed. R. Civ. P. 34 will be governed by the standards applicable to written discovery under Fed. R. Civ. P. 26 through 37. The questions and requests for production contained in the Fact Sheet are non-objectionable and shall be answered without objection.

In filling out this form, please use the following definition: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In addition, to the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary.

PLAINTIFF'S PRELIMINARY STATEMENT

1. Many of the questions call for information / answers that are set forth in documents/ records which Plaintiff is producing and will produce during the course of pre-trial discovery or that Defendants will retrieve with the use of the various Authorizations being provided. The answers provided herein were based on the Plaintiffs best recollection at the time of the completion of this Fact Sheet and based on those records retrieved and available as of the date of the completion of this Fact Sheet.

2. Plaintiff reserves the right to amend or supplement any and all answers to this Fact Sheet during the course of pre-trial discovery.

Amended Exh. H

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3. Plaintiff is not a "healthcare provider" and any statements or opinions regarding her condition or diagnosis are based upon her lay person's view, and her layperson's understanding of medical terminology contained in this fact sheet.

4. Plaintiff reserves the right to amend or supplement any and all answers to this Fact Sheet as records are ordered, retrieved and produced during the course of pre-trial discovery.

5. This Preliminary Statement is incorporated in each and every answer set forth in the answers below and any amended answers and/or supplemental answers to be provided during the course of pre-trial discovery.

I. CASE INFORMATION

1. Please state the following for the civil action that you filed:

   a. Case caption: [redacted] v. Actavis Group hf et al.

   b. Civil Action Number: 08-[redacted])

   c. Court in which action was originally filed: New Jersey

   d. Your attorney:

      Name: John R. Malkinson, Malkinson & Halpern PC

      Address: 223 W Jackson Blvd., Suite 1010, Chicago, IL 60606

2. Name of person completing this form: [redacted]

3. Please list any other names you have used or by which you have been known and dates you used those names: N/A

4. Your current address: [redacted]

5. If you are completing this Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

   a. Describe the capacity in which you are representing the individual or estate: N/A

   b. If you were appointed as a representative by a court, state the:

      Court Which Appointed You: N/A

      Date of Appointment: N/A

   c. What is your relationship to the individual you represent: N/A

   d. If you represent a decedent's estate, state:

      Decedent's Date of Death: N/A

      Address of Place Where Decedent Died: N/A

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e. If you are claiming the wrongful death of a family member, identify any and all family members, beneficiaries, heirs or next of kin of that person, including their relationship to Decedent:

N/A

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO PURCHASED, OR PURCHASED AND USED DIGITEK®. WHETHER YOU ARE COMPLETING THIS FACT SHEET FOR YOURSELF OR FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE DIGITEK® PURCHASER OR PURCHASER AND USER.

II. CLAIM INFORMATION

1. Name of Digitek® Purchaser/User: [redacted]

2. Have you used any other names in the last five (5) years? **Yes** ☐ **No** ☒

   If **yes**, please list any such names that you have used: N/A

3. Do you claim that you suffered bodily injuries as a result of taking Digitek®?

   Yes ☒ **No** ☐ If **Yes**, please answer the following:

   a. What bodily injuries do you claim resulted from your use of Digitek®?

   Subject to Plaintiff's Preliminary Statement, above: Various conditions including, heart palpitations and fibrillation. Pain in left shoulder. See also, medical records. Periodic disorientation/confusion. Investigation continues.

   b. When is the first time you saw a health care provider for any of the symptoms you link to your alleged injury? See relevant medical records. Investigation continues.

   c. Are you currently experiencing symptoms related to your alleged injury?

   Yes ☒ **No** ☐ If **Yes**, please describe the symptoms: Heart palpitations. Investigation continues.

   d. Did you see a doctor, clinic or healthcare provider for the bodily injuries or illness listed above?

   Yes ☒ **No** ☐ If **Yes**, who: Dr. Pankaj Patel .

   e. Who diagnosed your injury? Dr. Pankaj Patel evaluated me.

   f. Date of diagnosis: Investigation continues. See also medical records.

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g. Were you hospitalized?

Yes ☐ **No** ☒ If **Yes**, please answer the following:

1) Date of hospital admission: _____

2) Date of discharge: _____

3) Hospital name and address: _____

h. What harm or consequence including physical limitations, do you claim you suffered as a result of the bodily injury above, excluding any mental or emotional damages, lost wages or out of pocket expenses listed below?

Subject to Plaintiff's Preliminary Statement, above: frequent exhaustion, rapid heart beat, mental confusion. See also 3(a) above, and relevant medical records. Investigation continues.

i. Do you claim that your injury was caused by ingesting defective Digitek® medication?

Yes ☒ **No** ☐ If **Yes**, please answer the following:

1) Describe in detail what you claim the defect to have been in the Digitek® medication that you ingested: See Plaintiff's Complaint.

2) How much of the defective product did you ingest? Investigation continues.

3) When did you ingest the product? To my recollection, I began taking Digitek regularly in approximately 2005. See medical records.

j. Have you had any discussions with any doctor or other healthcare provider about whether Digitek® caused you to suffer any illness or injury?

Yes ☒ **No** ☐ If **Yes**, who: Dr. [redacted]

4. Are you claiming mental and/or emotional damages as a result of taking Digitek®?

Yes ☒ **No** ☐

If **Yes**, what mental and/or emotional damages do you claim resulted from your use of Digitek®?

I had incidents of mental confusion, including mental confusion while driving. Those experiences have also caused past and present anguish and anxiety.

If **Yes**, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, state the following:

NAME	ADDRESS	CONDITION TREATED	DATES TREATED	MEDICATIONS PRESCRIBED
Dr. [redacted]	See Section VII(1)			

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5. Are you making a claim for lost wages or lost earning capacity?

Yes ☐ **No** ☒ If **Yes**, state the annual gross income you derived from your employment for each of the last five (5) years:

N/A

6. Have you incurred any out-of-pocket expenses as a result of using Digitek®?

Yes ☒ **No** ☐ If **Yes**, please identify and itemize all out-of-pocket expenses you have incurred:

Payments for related and post-recall-related medical care, physician appointments, medical tests, including, any EKG, blood tests, stress test, cat scan, medical records, etc. Investigation continues.

7. What other damages, if any, do you claim you suffered as a result of the purchase or ingestion of Digitek®?

Investigation continues.

III. DIGITEK® PRESCRIPTION INFORMATION

1. Have you ever used Digitek®? **Yes** ☒ **No** ☐

2. If you answered **yes** to No. 1, identify the following for each period of time during which you took Digitek®:

DOSAGE (.125 MG OR .250 MG)	HOW OFTEN PER DAY OR WEEK?	DATE STARTED	DATE STOPPED	NAME OF PRESCRIBER
.125 mg	1 x day	Approximately 2005; See medical records.	Approximately April 29 2008; See medical records	Dr. [redacted]

3. Name(s) and address(es) of pharmacies where prescriptions were filled: Osco Dru g. [redacted] Street, [redacted] 60546.

4. Identify the condition for which you were prescribed Digitek®: As I understand it, Heart Arrhythmia.

5. Did you receive any free samples of Digitek®?

Yes ☐ **No** ☒ If **Yes**, please state the following:

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a. Who provided the samples? _____

b. When were samples provided? _____

c. What was the dosage of the samples? _____

d. How many samples were provided? _____

6. Do you have in your possession or does your attorney have the packaging from the Digitek® you allegedly purchased, or purchased and used, and/or any Digitek® tablets?

Yes ☒ **No** ☐

a. If yes, who currently has custody of the Digitek® packaging and/or tablets?

Attorney John R. Malkinson has some left-over tablets.

b. If you or your attorney is in possession of tablets, how many do you have? Around 19 pills.

c. Have you or anyone on your behalf tested the Digitek® tablets in your possession?

Yes ☐ **No** ☒ If **Yes,**

1) Who tested the tablets?_____

2) What test(s) was performed?_____

3) How many tablets were tested?_____

4) When were the tests performed?_____

5) What were the test results?_____

(NOTE: In lieu of answering the following Question Nos. 7a and 7b, please attach a clear copy of the product packaging and/or the label on the vial or blister pack of Digitek® in your or your attorney's possession that provides the information sought below.)

7a. Do you know the lot number(s) for any of the Digitek® you received?

Yes ☐ **No** ☒

If **Yes**, what is/are the lot number(s): _____

7b. Do you know the expiration date for any of the Digitek® you received?

Yes ☐ **No** ☒

If **Yes**, when is/was/were the expiration date(s): _____

8. Have you had any communication, oral or written, with any of the defendants or their representatives?

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Yes ☐ No ☒ None recalled.

If **Yes**, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and any defendants or their representatives:

9. Have you ever used any other digoxin or digitalis product (i.e. Lanoxin)?

Yes ☒ No ☐

If **Yes**, please state:

DOSAGE (.125 MG OR .250 MG)	HOW OFTEN PER DAY OR WEEK?	DATE STARTED	DATE STOPPED	NAME OF PRESCRIBER
☒ .125 mg ☐ .250 mg	1 every other day	Approximately April 29 2008; see medical records.	Current	Dr. Pankaj Patel
☐ .125 mg ☐ .250 mg				
☐ .125 mg ☐ .250 mg				

10. Are you aware that Digitek® was recalled?

Yes☒ No ☐ If **Yes**, please state the following:

a. When you became aware of the recall: In aprroximately April 2008. Investigation continues.

b. How you became aware of the recall: The Pharmacist (Osco Drug).

11. Did you discuss the recall with any healthcare provider or pharmacist?

Yes☒ No ☐If **Yes**, please state the following:

a. When that discussion occurred: In aprroximately April 2008. Investigation continues.

b. With whom: Osco Pharmacist and Dr. Patel.

12. Did you return any Digitek® to Stericycle or any pharmacy?

Yes ☒ No☐ If **Yes**, please state the following:

a. When did you return the product? Shortly after learning of the Recall a few tablets were returned.

b. Do you have your paperwork regarding the return? **Yes ☐No ☒**

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c. To whom did you return the product? Osco Drug.

13. Have you ever visited a website, chat-room, message board or other electronic forum containing information or discussion about Digitek®?

Yes ☐ **No** ☒ If **Yes**, please provide the name of the website:_____

IV. MEDICAL BACKGROUND

1. Current Height: 5' 5 ½"

2. Current Weight: 172

3. Approximate weight at the time of your injury: 176

4.A. To the best of your knowledge, have you, or any blood-relative family member (child, parent, brother, sister, or grandparent), ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please identify who suffered the condition, you or a relative, and please provide the relative's name and relationship to you. If you suffered the condition, please provide the additional information requested in the table following 4(B):

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO	WHO SUFFERED CONDITION
Abnormal heart rhythm, atrial fibrillation, atrial flutter, ventricular fibrillation, or heart block	☐	☐	Grandmother-Heart attack- Investigation conitinues.
Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)	☐	☒	
Blocked or narrow arteries/plaque buildup/coronary artery disease	☐	☒	
Cardiomyopathy/enlarged heart	☐	☒	
Chest pain/angina	☐	☒	
Congenital heart abnormality	☐	☒	
Congestive heart failure	☐	☒	
Heart attack/MI/myocardial infarction	☐	☒	
High blood pressure/hypertension	☒	☐	Me
High cholesterol or triglycerides	☒	☐	Me
Kidney disease or condition	☐	☒	
Stroke/transient ischemic attack/TIA/aneurysm	☐	☒	

4.B. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. If you suffered the condition, please provide the additional information requested in the table following this chart:

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO
Alcoholism or other substance abuse	☐	☒
Alzheimer's, senility, confusion	☐	☒
Arthritis (osteoarthritis or rheumatoid arthritis)	☒	☐
Autoimmune diseases (e.g., rheumatoid arthritis, lupus, Sjogren's, etc.)	☐	☒
Bleeding or clotting disorders	☐	☒
Cancer	☐	☒

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CONDITION EXPERIENCED OR DIAGNOSED	YES	NO
Chronic obstructive pulmonary disease/COPD/chronic lung disease/asthma	☐	☒
Deep vein thrombosis/DVT	☐	☒
Depression, anxiety, schizophrenia, bipolar disorder	☐	☒
Dermatologic diseases or conditions	☐	☒
Diabetes mellitus	☐	☒
Electrolyte imbalance	☐	☒
Enlarged prostate, bladder dysfunction	☐	☒
Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD, increased or decreased motility)	☒	☐
Hardening of the arteries/stenosis/aneurysms	☐	☒
Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)	☐	☒
Hormonal replacement therapy	☐	☒
Hypothyroidism/Thyroid condition	☐	☒
Immune system disease or dysfunction (including HIV or AIDS)	☐	☒
Liver disorder or disease (cirrhosis, hepatitis, etc.)	☐	☒
Multiple sclerosis, myasthenia gravis	☐	☒
Osteoporosis, bone fractures, calcium deficiency	☐	☒
Peripheral vascular disease or peripheral arterial disease	☐	☒
Pulmonary embolism/blood clot to the lungs	☐	☒
Pulmonary hypertension	☐	☒
Raynaud's syndrome/phenomenon	☐	☒
Rheumatic Fever/Scarlet Fever	☐	☒
Tobacco use or addiction	☐	☒
Vasculitis	☐	☒

For each condition for which you answered **Yes** in the previous two charts, please provide the information requested below:

CONDITION YOU EXPERIENCED	DATE OF ONSET	MEDICATION/ TREATMENT	TREATING PHYSICIAN AND/OR HOSPITAL
Arthritis	Approximately 2000	Piroxicam	Dr. [redacted]
Acid Reflux	Approximately 2001	N/A	Dr. [redacted]
High Blood Pressure	Approximately 1980's	Off/On. Do not recall	[redacted] Hospital Dr.'s
High Cholesterol/ Triclycerides	Approximately 1990's	Do not recall	Do not recall

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CONDITION YOU EXPERIENCED	DATE OF ONSET	MEDICATION/ TREATMENT	TREATING PHYSICIAN AND/OR HOSPITAL

5. Please indicate whether you have ever been the subject of any **cardiovascular surgeries** including, but not limited to, open heart/bypass surgery, CABG, pacemaker or defibrillator implantation, stent placement, vascular surgery, angioplasty, IVC filter placement, carotid (neck) surgery, or valve replacement.

Yes ☐ **No** ☒ I don't recall ☐ If **Yes**, please specify the following:

SURGERY	REASON FOR SURGERY	DATE	TREATING PHYSICIAN	HOSPITAL

6. Please indicate whether you have ever been the subject of any of the following **cardiovascular diagnostic tests** or interventions and provide the requested information about each: including, but not limited to, stress test C-reactive protein (CRP); chest X-ray; angiogram/catheterization; CT scan; MRI; EKG; echocardiogram; TEE (trans-esophageal echo); endoscopy; lung bronchoscopy; carotid duplex/ultrasound; MRI/MRA of the head/neck; angiogram of the head/neck; CT scan of the head; bubble/microbubble study; and Holter monitor.

Yes ☒ **No** ☐ I don't recall ☐ If **Yes**, please specify the following:

DIAGNOSTIC TEST/ INTERVENTION	REASON FOR TEST/ INTERVENTION	DATE	TREATING PHYSICIAN/ HOSPITAL	RESULT OF DIAGNOSTIC TEST/ INTERVENTION
CT Scan	Heart	6/08	[redacted] Suburban Hospital	Not known to me.
Echo Cardiogram	Heart	6/08	[redacted] Clinic	Not known to me.
Stress Test	Heart	6/08	[redacted] Suburban Hospital	Not known to me.

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7. Do you now or have you ever smoked tobacco products? **Yes** ☐ **No** ☒ If **Yes**, please specify the following:

   a. How long have/did you smoke? _____

   b. How much do/did you smoke? _____

8. Did you drink alcohol (beer, wine, etc.) in the three years before your alleged injury?

   Yes ☐ **No** ☒ If **Yes**, please specify the following:

   a. How often did you drink? _____

   b. How much did you drink? _____

9. Have you ever used any illicit drugs of any kind within the five (5) years before, or at any time after, your alleged injury?

   Yes ☐ **No** ☒ If **Yes**, identify the substance(s) and your first and last use: _____

V. ADDITIONAL MEDICATIONS (INCLUDING OTHER DIGOXIN PRODUCTS, SUCH AS LANOXIN®)

1. For any medications, herbal products or supplements other than Digitek® that you took on a regular basis in the ten (10) years prior to, and at the time of, the incidents described in your Complaint, please provide the information requested below.

SEE ANSWERS ABOVE, ADDITIONALY:

NAME OF MEDICATION USED	DOSAGE	PRESCRIBING PHYSICIAN	DATES OF USE	PURPOSE OF PRESCRIPTION
Warfarin	.5 mg	Dr. [redacted]	Approximately 2005 – current	Due to heart condition
Lisinopril	40 mg	Dr. [redacted]	Approximately 2005 – current	Cholesterol
Verapamil	240 mg	Dr. [redacted]	Approximately 2005 – current	High blood pressure
Simvastatin	40 mg	Dr. [redacted]	Approximately 2005 - current	High blood pressure
Digoxin	125 mg	Dr. [redacted]	Approximately 2008 – current	Palpitations

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NAME OF MEDICATION USED	DOSAGE	PRESCRIBING PHYSICIAN	DATES OF USE	PURPOSE OF PRESCRIPTION

2. Have you ever experienced any side effects while you were taking any of the medications identified in this section in the past ten (10) years?

Yes ☒ **No** ☐ If **Yes**, please specify the following:

a. The name of the medication: Digitek

b. The side effect(s): See numbers 3 and 4 above. Investigation continues.

c. The date the side effect was experienced: See answers above.

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VI. PERSONAL INFORMATION

1. Current Address and Date when you began living at this address: [redacted]

2. Social Security Number: [redacted]

3. Date and Place of Birth: [redacted]

4. Marital Status: Married

   If married, spouse's name, occupation and date of marriage: [redacted] Retired.

   If divorced, dates of the marriage, case name/jurisdiction for the divorce: _____

   Has your spouse filed a loss of consortium in this action? **Yes** ☐ **No** ☒

5. If you have children, please list each child's name and date of birth:

   [redacted]

   _____

6. For any school attended after High School, please provide the following information:

   a. School Name: [redacted]

   b. Address: [redacted] Centra[redacted]

   c. Dates attended: 1991

   d. Diploma/Degree: Certificate in Nursing Assistant.

7. Employment information for the last ten (10) years. Please include employer's name, address, dates of employment, job title, job description and duties:

   Reliable Bus Company, Chicago, IL, September 1998 – September 1999, 4 hrs. a day, Bus Attendant, helped

   Handicap children on and off the bus.

8. Have you ever served in the military, including the military reserve or National Guard?

   Yes ☐ **No** ☒

   If **Yes**, were you ever rejected or discharged from military service for any reason relating to your physical condition? **Yes** ☐ **No** ☐

   If **Yes**, state the condition for which you were rejected or discharged: _____

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9. Has any insurance or other company, or Medicare or Medicaid, provided medical coverage to you or paid medical bills on your behalf in the last ten (10) years?

Yes ☒ **No** ☐ If **Yes**, please specify the following:

a. The name of the company/agency: Humana HMO

b. Address: P.O. Box 14601 Lexington, KY 40512

c. Dates of Service: Ten years (1999 – Current)

10. Have you applied for workers' compensation (WC) and/or social security disability (SSI or SSD) benefits in the last ten (10) years?

Yes ☐ **No** ☒ If **Yes**, please specify the following:

a. Type of claim: _____

b. Year application filed: _____

c. Agency where application was filed: _____

d. Nature of disability: _____

e. Time period of disability: _____

11. Have you filed a lawsuit or made a claim in the last ten (10) years, other than in the present suit, relating to any bodily injury?

Yes ☐ **No** ☒ If **Yes**, please specify the following:

a. Court in which suit/claim filed or made: _____

b. Case/Claim Number: _____

c. Nature of Claim/Injury: _____

12. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?

Yes ☐ **No** ☒ If **Yes**, please set forth where, when and the felony and/or crime: _____

VII. HEALTHCARE PROVIDERS AND PHARMACIES

1. Identify each doctor or other healthcare provider who you have seen for medical care and treatment in the past ten (10) years:

NAME AND SPECIALTY	ADDRESS	REASON FOR VISIT	APPROX DATES/YEARS OF VISITS
Dr. [redacted]	6434 [redacted]	High blood pressure	1999 - current

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NAME AND SPECIALTY	ADDRESS	REASON FOR VISIT	APPROX DATES/YEARS OF VISITS

2. Identify each hospital, clinic, or healthcare facility where you were hospitalized (in-patient, out-patient, or emergency room visit) in the past ten (10) years:

Investigation continues. Presently recalled are:

NAME	ADDRESS	ADMISSION DATE(S)	REASON FOR ADMISSION
West Suburban Hospital	35001 [redacted]	2/01	Knee replacement
	1[redacted] Ct. [redacted]	2/05	Gastrointestinal

3. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

NAME OF PHARMACY	ADDRESS	APPROX DATES/YEARS YOU USED PHARMACY
Osco Drug	72[redacted] W [redacted] St [redacted]	1999

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VIII. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. If you are filling this out on behalf of an individual who is deceased, please state the following from the Death Certificate of the individual:

(NOTE: In lieu of the following, please attach a copy of the death certificate.)

Date of death: _____
Place of death (city, state and county): _____
Facility or location where death occurred: _____
Name of physician who signed death certificate:_____
Cause of death: _____
If you are filling this out on behalf of an individual who is deceased and on whom an autopsy was performed, please fill in the information below pertaining to the autopsy and the autopsy report:

(NOTE: In lieu of the following, please attach a copy of the autopsy report.)

Date: _____
Performed by: _____
Facility where autopsy was performed: _____
Place where autopsy was performed (city, state, county): _____
Describe any and all tissue preserved: _____

IX. FACT WITNESSES

1. Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name address and his/her/their relationship to you:

Name: [redacted]
Address: [redacted]
Relationship to you: [redacted]

Name: _____
Address: _____
Relationship to you: _____

Name: _____
Address: _____
Relationship to you: _____

Name: _____
Address: _____
Relationship to you: _____

Name: _____
Address: _____
Relationship to you: _____

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IX. DOCUMENT DEMANDS

1. Authorizations: please sign authorizations that are attached hereto as Exhibit A, for each of the healthcare providers that you have identified above in your Answers to §II, Question Nos. 1-3, and § IV, Question No. 2.

2. Documents in your possession, including writings on paper or in electronic form: If you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet.

   a. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Digitek®.

   b. Copies of the entire packaging, including the box and label, for Digitek® and any Digitek® tablets (plaintiffs or their counsel must maintain the originals of the items requested in this subpart).

   c. All documents relating to your purchase of Digitek®, including, but not limited to, receipts, prescriptions or records of purchase.

   d. All photographs, drawing, journals, slides, videos, DVDs or any other media relating to your alleged injury.

   e. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).

   f. Decedent's death certificate and autopsy report (if applicable).

   g. Medical records, bills, correspondence, reports and all other documents from any health care provider who saw, evaluated or treated Plaintiff/Decedent in the last five (5) years.

   h. All emergency responder, paramedic or EMT reports regarding Plaintiff/Decedent.

   i. Documents concerning any communication between Plaintiff/Decedent or Plaintiff/Decedent's attorneys or agents and the FDA or any Defendant regarding the events giving rise to the lawsuit or relating to Digitek.

   j. Non-privileged documents, including any diaries, calendars or notes that record Plaintiff/Decedent's health, use of Digitek or alleged injuries

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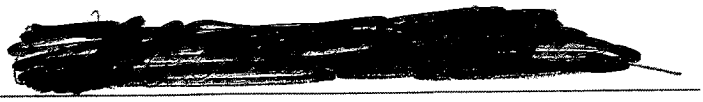
X. VERIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge. I have supplied all the documents requested in Part ___ of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and supplied the authorizations attached to this declaration.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respects incomplete or incorrect.

Date: X 4-22-09

X 

Signature